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Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, \$2.00 per year.

Volume XXXVII, No. 1

January, 1954

TABLE OF CONTENTS

	PAGE
SURGICAL MANAGEMENT OF MITRAL STENOSIS, <i>Jesse P. Eddy, 3D, M.D., Jacob Greenstein, M.D., Gary P. Paparo, M.D., Howard W. Umstead, M.D., and Robert Rosin, M.D.</i>	19
OSTEOID OSTEOMA, <i>Stanley Simon, M.D. and Carroll M. Silver, M.D.</i>	23
PSYCHIATRIC PROBLEMS ASSOCIATED WITH THE AGING, <i>Laurence A. Senseman, M.D., F.A.C.P.</i>	30
OSTEOPATHY IN NEW ENGLAND, <i>John E. Farrell, SC.D.</i>	50

EDITORIALS

Polio Vaccine	36
Hospital Accreditation	37
Public Reaction	37
Medical-Pharmaceutical Forum	37
Four Hundred Thousand	38

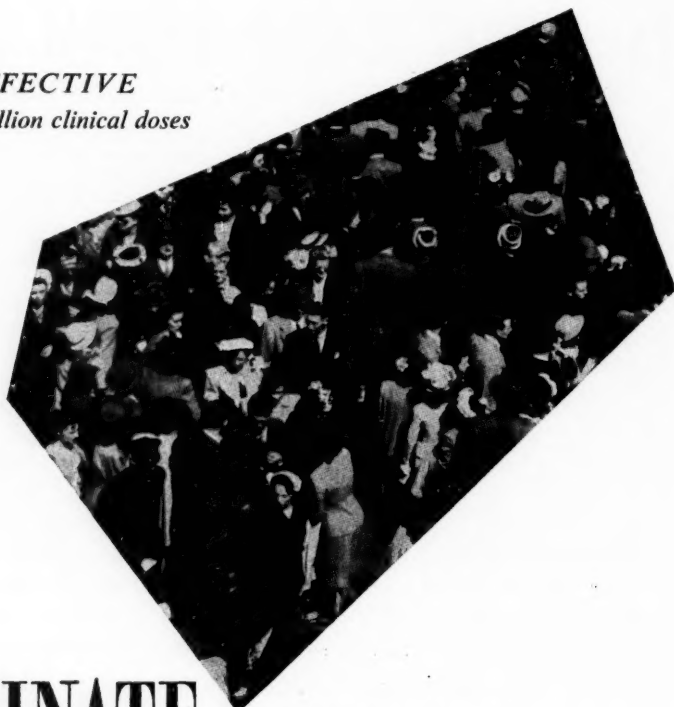
DEPARTMENTS

Delegate to the AMA, Report of AMA Interim Meeting	40
District Medical Society Meetings	42
R. I. Medical Society — Necrology, 1953	47
Book Review	58

MISCELLANEOUS

Photograph: Joseph B. McKenna, M.D.	42
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SURGICAL MANAGEMENT OF MITRAL STENOSIS*

A Panel Discussion

JESSE P. EDDY, 3d, M.D., JACOB GREENSTEIN, M.D.,
GARY P. PAPARO, M.D., HOWARD W. UMSTEAD, M.D.,
AND ROBERT ROSIN, M.D.

The Authors. *Jesse P. Eddy 3d, M.D., Director of Vascular Clinic, and Surgeon, Department of Surgery; Jacob Greenstein, M.D., Physician-in-Chief; Gary P. Paparo, M.D., Pathologist; Howard W. Umstead, M.D., Chief Anesthetist; Robert Rosin, M.D., Roentgenologist, all of The Memorial Hospital, Pawtucket, R. I.*

DR. GREENSTEIN

The medical treatment of mitral stenosis is purely symptomatic and does nothing to correct the mechanical narrowing of the mitral orifice. It is this narrowing which causes back pressure in the pulmonary circuit, resulting in pulmonary hypertension with its accompanying symptoms.

DR. PAPARO

Practically all cases of mitral stenosis are caused by rheumatic endocarditis.

The pathological sequences are usually verrucae formation followed by fusion of the commissures resulting in progressive narrowing of the mitral orifice. There is dilatation, then hypertrophy of the left auricle, increasing pulmonary hypertension, chronic progressive congestion of the lungs, hypertrophy of the right ventricle followed by right ventricular failure with relative insufficiency of the tricuspid valve, and finally general circulatory decompensation.

DR. GREENSTEIN

The rationale behind mitral valve surgery for stenosis is; to enlarge the orifice to relieve pulmonary hypertension.

As a result of a better understanding of the pathological physiology, together with improvements in surgical technique and in the field of anesthesia, and with the improved control of infection by chemotherapy and antibiotics, the surgical treatment of mitral stenosis is not only feasible but relatively safe in properly selected cases.

*Presented at the John F. Kenney Memorial Clinic Day of the Memorial Hospital Interns' Alumni Association, at Memorial Hospital, Pawtucket, R. I., November 5, 1952.

Clinical Manifestations

The principal clinical manifestations of increasing pulmonary hypertension are:

1. Cough,
2. Dyspnea on exertion,
3. Hemoptysis,
4. Varying degrees of pulmonary edema, and finally
5. Right heart failure.

Indication for Surgery

The main indication for surgery is early evidence of progressive pulmonary hypertension in pure mitral stenosis with little or no evidence of associated mitral regurgitation or other valvular lesions.

Contraindications

The contraindications are:

1. Marked mitral regurgitation,
2. Aortic valvular disease, especially aortic stenosis,
3. Fixed pulmonary hypertension,
4. Chronic congestive heart failure (intractable),
5. Active rheumatic carditis, and
6. Bacterial endocarditis.

Diagnostic Procedures

The minimal diagnostic procedures involved in the selection of cases for surgery are:

1. An adequate history with special reference to possible previous rheumatic infection and symptoms of pulmonary hypertension.
2. Physical findings consistent with rheumatic mitral stenosis.
3. Electrocardiogram for alterations in size and configuration of P waves, changes in rate, rhythm, and ventricular preponderance. There should be no evidence of left ventricular preponderance inasmuch as this may indicate that we are probably dealing with more than mitral stenosis.
4. X-ray and fluoroscopy.

continued on next page

5. Routine laboratory work including blood chemistry, sodium, potassium, and chlorides.

Other procedures, such as angiocardiology, cardiac catheterization, and phonocardiography, may be necessary in doubtful cases.

X-ray and fluoroscopy are of considerable value in the diagnostic work-up.

DR. ROSIN

In the great majority of cases a simple fluoroscopic examination of the chest, with barium in the esophagus, followed by routine filming in various projections will afford the essential information. The radiographic work-up, in addition to revealing essential information in regard to the size of the heart, abnormalities of contour, and the status of the pulmonary vessels, will also reveal any complicating conditions in the other intra-thoracic or extra-thoracic structures; conditions which might have a direct bearing in regard to the operability or inoperability of the patient.

From the roentgen standpoint, the single criterion that allows one to make a presumptive diagnosis of mitral stenosis is demonstrable enlargement of the left auricle. Other findings may be enlargement of the right ventricle, increased activity of the hilar vessels and increased pulmonary vascularity.

DR. GREENSTEIN

Selection of Cases

In the selection of cases for operation, the patients are divided into four main groups:

- Group I are those who have no symptoms.
- Group II are those with symptoms of pulmonary hypertension on moderate or extreme effort, but otherwise appear stationary.
- Group III are those patients who are progressively incapacitated, showing symptoms on slight exertion, effort, or excitement.
- Group IV are those with chronic congestive failure, in spite of treatment, with probable fixed, irreversible pulmonary hypertension.

Of these four groups:

- Group I (asymptomatic) does not require operation.
- Group II and more especially Group III represent the patients who should be operated and probably will benefit most from surgery.

Patients in Group IV, although most desperately in need of relief, are the poorest surgical risks and, in general, derive the least benefit.

Preparation for Operation

After the patients have been selected for operation, they are properly prepared with digitalis, diuretics, and diets as indicated and are given antibiotics pre-operatively.

We have found it desirable to determine sodium, potassium, and chloride values pre-operatively as well as post-operatively since vigorous pre-operative diuresis and operative and post-operative sweating may result in a "low salt syndrome."

During the operation, a continuous electrocardiogram is taken. Electrocardiographically, the heart appears to withstand mitral valve surgery well. In our series of fifteen cases of mitral commissurotomy, we observed only transient changes in rate, rhythm, etc. without any associated clinical effect. None of these required any treatment and all disappeared spontaneously. Pre-operatively, six of our cases showed auricular fibrillation and nine showed a normal sinus rhythm.

Auricular fibrillation is not a contraindication for operation nor is previous embolization. In fact, ligation of the auricular appendage, which is done incidental to mitral valvuloplasty, has been recommended as a preventive for recurrent emboli. Two of our patients had peripheral embolization prior to operation with no recurrence of embolic phenomena even though they have continued to have paroxysmal fibrillation.

The changes which we have observed are:

1. Tachycardia.
2. Bradycardia.
3. Nodal rhythm.
4. Auricular ectopic beats and auricular fibrillation.
5. Ventricular ectopic beats.
6. Bigeminy.
7. Auricular flutter.
8. Minor ST segment depressions or elevations.

There appeared to be no constant relationship between any of these changes and any specific anesthetic or operative procedure, such as endotracheal intubation, rib spreading, cutting the pleura, or manipulation of or surgical procedures on the pericardium and various portions of the heart.

The most common electrocardiographic abnormality observed was transient runs of ventricular ectopic beats which occurred during fracture or cutting of the AV valve.

Electrocardiographic abnormalities if persistent and associated with symptoms such as hypotension, or if they portend serious possibilities, must be dealt with promptly. This is especially true of ventricular tachycardia which may lead to ventricular fibrillation and cardiac arrest.

Some of the drugs¹ found to be useful for significant electrocardiographic abnormalities are:

1. Pronestyl 200 mgs., i.v., for ventricular tachycardia and ventricular ectopic beats.
2. Local procaine 1%, 10 c.c., in pericardial sac for ventricular disturbances.
3. Prostigmin, .25 mgs. i.v., for supraventricular disturbances including sinus tachycardia, paroxysmal auricular tachycardia, auricular fibrillation, auricular ectopic beats, and auricular flutter.
4. Atropine, .1 mg. i.v., for bradycardia.

If it were not for our present-day improved anesthetic procedures, heart surgery would not be possible.

DR. UMSTEAD

The basic problem in administering anesthesia for cardiac surgery is essentially the same as for any operation wherein the chest wall is opened widely. Satisfactory respirations may be established by applying the technique of endotracheal anesthesia.

The anesthetic agents employed to anesthetize patients undergoing cardiac surgery vary somewhat from clinic to clinic and usually reflect the personal choice of the anesthetists; e.g., nitrous oxide, ether, pentothal, curare, etc. Occasionally some concomitant pathology or known drug sensitivity may create a strong contra-indication for a particular agent.

Two of our patients received ether anesthesia and the remaining thirteen were given a combination of sodium pentothal-nitrous oxide-curare. All of the patients tolerated the anesthetics very well and no conclusions as to the merits of one particular method can be drawn from this small series.

DR. EDDY

The surgical treatment of mitral stenosis was first envisioned by Brunton² in 1902. He proposed a direct surgical reconstruction of the valve.

In 1907 Cushing and Branch³ operated upon two dogs with mitral stenosis. Graham and Allen⁴ developed a cardioscope in 1920 whereby they could visualize the heart and valve in dogs. Cutler⁵ in 1923 operated upon the first human case via a transventricular approach and partially incised the valve in a girl who subsequently had a four year survival. Souttar⁶ in 1925 reported the second human survival and is credited by Hufnagel⁷ with being the first to use the auricular appendage as the approach to the valve, the technique which is favored today in this operation. In 1929 Cutler and Beck⁸ made a final analysis of all cases which had been reported in the literature up to that time, ten in number. Only one survivor was then living, and because of this rather dismal situation, the pro-

cedure was abandoned for many years to come.

In 1948 Smithy⁹ reported the excision of a portion of the mitral ring, but it was not until Bailey¹⁰ with his operation of commissurotomy and subsequently Harken^{11, 12} with his of valvuloplasty was this surgical therapy for mitral stenosis really put upon its feet and since then become increasingly common practice.

The value of teamwork is important. These patients are all carefully evaluated by the internist, cardiologist, anesthetist, and surgeon, and when they come to the operating theatre, should be in an optimum condition. The surgical therapy itself is not unduly complicated or time-consuming. It is important, however, that a surgical team be constituted which is familiar with the operation and with one another, as this greatly facilitates the procedure. This applies to the operating room personnel as well as the surgeons and anesthetists.

It has been our practice to establish a cut-down in one of the veins of the forearm for any indicated intravenous solutions, or blood if necessary, although, in general, blood is contra-indicated in these operations.

A long posterolateral incision is made over the left fifth rib from the costochondral junction to the transverse process and this rib is either resected or the left fourth or fifth interspace directly opened. Rib spreaders are then introduced which provide an adequate exposure. The left lung is permitted to collapse and any adhesions which may be present and tend to interfere with the cardiac exposure are divided. The lung is then gently retracted posterolaterally. The pericardium is opened longitudinally, generally just posterior to the left phrenic nerve, and stay sutures may be utilized in the pericardium to firmly anchor it to the chest wall, thereby stabilizing the heart and further serving to keep the lung out of the way. A small amount of fluid is generally encountered within the pericardial sac which is suctioned away. At this junction, the heart should be carefully palpated with the examining finger to further confirm the diagnosis and evaluate the situation as it exists in the individual case. A mitral diastolic thrill may be felt over the ventricle in most cases. The size of the auricular appendage and the pulmonary artery are carefully noted. In pulmonary hypertension that results from mitral stenosis, the pulmonary artery is greatly enlarged and hypertrophied. The left auricular appendage is also carefully inspected and palpated. It should be enlarged and apparently under tension. A small appendage usually means an incorrect diagnosis or else thrombosis within the appendage or left auricle. A large left auricular appendage is one of the best signs that we have of pulmonary hypertension and it also tends to indi-

continued on next page

cate a favorable surgical entrance into the heart itself. A small auricular appendage offers serious complications toward getting within the heart for a surgical attack upon the mitral valve, and in some instances can prevent entrance via that route. Careful palpation of the appendage should reveal the size of the opening into the auricle and give some indication as to whether or not the valve should be approached by other means, such as the left superior pulmonary vein or auricle itself. The necessity of this, fortunately, is rare.

The base of the auricular appendage is then carefully tested with a special clamp, usually a Satinsky or Craaford clamp, to determine the location of the purse-string suture and also the type of clamp which best suits the particular appendage, so that the purse-string suture may be properly placed. It is this suture, or lifeline, which is so vital to the operation. It consists of #0 braided white silk swedged on a curved needle which is carefully placed about the base of the appendage and its end secured by a special tourniquet holder which greatly facilitates the technical aspects of the procedure to follow. The previously selected appendageal clamp is then placed on the base of the auricular appendage and an incision made distal to this which opens it up, permitting the escape of the trapped blood within the appendageal cavity. Thromboses if present, are noted at this time and it is good technical practice, if such are encountered, to lightly release the clamp and permit the escape of blood from within the auricle to wash out the clot or clots if they are present.

Next, the gloved finger is introduced within the appendage down as far as the clamp and as this clamp is gradually opened, the finger is pushed within the auricle itself and the purse-string suture is gently snugged up so that there is little, if any, escape of blood. Careful inspection can be made within the left auricle with more or less impunity, as this procedure does not affect the heart adversely. If a Lukenbacher's syndrome is suspected, palpation will reveal the intra-atrial septal defect. When the finger is in the region of the mitral valve, the presence or absence of regurgitation can be detected, for the regurgitant stream against the index finger feels exactly like the flow of water from a faucet. The mitral valve should then be inspected and any thickening or fibrosis, narrowing, and calcification noted. Once the finger is introduced into the mitral valve, however, speed is essential as this act obstructs the flow of blood through the heart and cannot be tolerated but for a few seconds.

With the patient lying in the postero-lateral position the commissures are lying in a horizontal axis to the body. The first maneuver is to push the

finger through the opening in such a manner as to fracture the anterior commissure or dilate the valve so that an adequate opening is created. Ideally this opening should be $1\frac{1}{2}$ to 2 fingers. In some instances, the valve will not fracture or split as desired and it is necessary to use the knife, and all surgeons doing this operation today use whatever method or combination of methods is necessary to produce the desired opening in the mitral orifice. The postero-medial commissure is seldom fractured or cut, as the obstruction is relatively unimportant here and the danger of cutting it much more serious.

Once an adequate opening has been made the finger is withdrawn from the heart and the appendageal clamp reapplied. A biopsy of the distal appendage is then taken and the opening in the appendage is closed with a running suture of fine silk. The clamp is removed and the purse-string suture tied snugly. This provides a double closure of the appendage and tends to obliterate it. The pericardium is loosely closed with a few interrupted silk sutures. A rubber drain under water-seal is placed within the chest and brought out through a stab wound anteriorly just above the antero-medial attachment of the diaphragm. The lung is re-expanded and the chest closed.

Following adequate opening of the mitral valve, the condition of these patients improves immediately, their blood pressure rising, their pulse slowing, and it is quite usual for them within an hour or two of their return to their room to state that they can breathe better than they could prior to the surgery. They are placed in oxygen for 24 hours and given careful post-operative treatment. I must say, however, that the majority of these patients with no serious complications do well following surgery and appear to need no more post-operative nursing care than the average major abdominal surgical case. They are dangled on the day following operation and are out of bed in two or three days. The chest tube is removed in 48 hours. We have removed the sutures around the tenth day and these patients usually go home in a day or two following this latter step.

Our first patient was operated on in July, 1951, and since that time we have done a total of fifteen patients. Two of these patients succumbed in the hospital and are counted as surgical mortality, giving us a present mortality rate of 13%.

The general country-wide mortality in Group IV cases is 25% and in Group II and III cases 5%. Our last eleven consecutive cases have been done without a loss. The results have been very gratifying. A complete analysis of our cases together with a follow-up will be presented in a forthcoming article.

concluded on page 56

OSTEOID OSTEOMA

STANLEY D. SIMON, M.D. AND CARROLL M. SILVER, M.D.

The Authors. Stanley Simon, M.D., Attending Orthopedic Surgeon, Miriam Hospital; Assistant Surgeon, Orthopedic Service, Pawtucket Memorial Hospital; Orthopedic Consultant, Providence Veterans Hospital. Carroll M. Silver, M.D., Chief of Orthopedic Surgery, Miriam Hospital; Assistant Surgeon, Department of Orthopedic Surgery and Fractures, Rhode Island Hospital.

OSTEOID OSTEOMA was first described by Jaffe¹ in 1935. In his original report of five cases the lesion developed within spongy bone. In a subsequent report, Jaffe and Lichtenstein² observed that the lesion frequently developed also in relation to the cortices of the shafts of long bones and that when it did so, it provoked remarkable sclerosis of the surrounding cortex out of proportion to the small size of the nidus. Such cases had previously been commonly misclassified as instances of "cortical bone abscess" or of "sclerosing nonsuppurative osteomyelitis."

Jaffe and Lichtenstein have defined an osteoid osteoma as a small, oval or roundish tumor-like nidus which is composed of osteoid and trabeculae of newly formed bone deposited within a substratum of highly vascularized osteogenetic connective tissue. The lesion, even when it is fully evolved, usually does not exceed a centimeter in its greatest dimension. It may develop either within the spongiosa, often at or near an articular surface, or in relation to the cortex of the affected bone. In the latter situation the lesion may be located within the cortex or abut against its inner surface (Case 1). When it develops within a spongy bone area, it provokes merely a thin rim of reactive sclerosis around it, but when it develops in relation to the cortex of a long bone, one commonly observes a perifocal zone of dense sclerotized cortical bone extending for a considerable distance beyond the osteoid osteoma *per se* (Cases 2 and 4).

AGE: The lesion may be encountered in young children, but it is more often seen in adolescents and young adults. It is relatively uncommon beyond the age of 30 years. Mayer,³ in his series of 19 cases reported in 1951, had four cases over 30, the eldest being 46.

LOCATION: The tibia and femur are most commonly involved. The other bones of the foot, the upper extremity, the vertebral column and pelvis are less common in the order mentioned. The skull and ribs have not been reported as sites by any observer.

DIAGNOSIS: The diagnosis of osteoid osteoma is not usually difficult if one is familiar with its clinical peculiarities and if it has progressed sufficiently to be demonstrable roentgenographically. The duration of symptoms varies from six months

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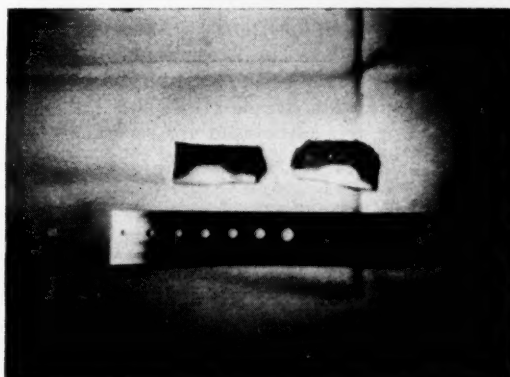


Figure 15

D.H. Case (4). Specimen typical of the osteoid osteoma developed within cortical bone.

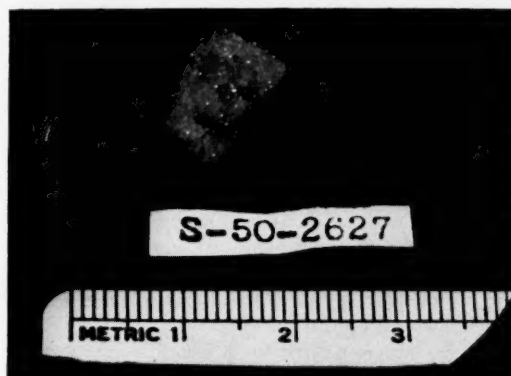


Figure 16

R.R. Case (1). Specimen typical of osteoid osteoma developed within spongiosa.

to two years (Case 4—? four years, treated for varicose veins; Case 3—Legg-Perthes ? three years). The chief complaint is pain, mild at first, but increasing in severity and persistence. A significant point is the amelioration of this bone pain by aspirin. Local swelling may become apparent in some instances and, in most, a sharply localized point of exquisite tenderness over the painful area can be demonstrated. Only rarely does one note slight local heat and redness and systemic reaction has not been correlated with this lesion. In some cases, the development of distressing pain may antedate the clear demonstration of the offending lesion in roentgenograms of the offending part, (Cases 1, 2) by some months or even a year or more. In such instances, the patients may be regarded for a time as malingerers or psychoneurotics. Mayer³ discussed the case of D.E. (#10), a classmate of one of the authors (S.D.S.) who had been treated for ankle pain by various orthopedists attached to the medical school where he was a student. An exploratory operation had been performed without success. This patient had been referred for psychiatric opinion and was considered a neurotic until excision of the osteoid osteoma relieved his pain.

The major problem in differential diagnosis occurs when the lesion develops within or just beneath a shaft cortex. In these instances the perifocal sclerotic area may extend for several inches above and below the lesion and the thickening of the cortex may be found to extend for a considerable distance around the circumference of the affected shaft area tending to obscure the small lesion which provokes it (Cases 2, 4). Frequently these lesions are difficult to distinguish from chronic sclerosing osteomyelitis and the definitive answer may have to wait on pathologic examination of the surgical specimen.

PATHOLOGY: The consensus of observers has reaffirmed Jaffe's original contention that this lesion is a peculiar benign tumor of bone of osteoblastic connective tissue derivation and is not a response to infection with peculiar healing, nor does it originate from an embryonic rest.

The gross and microscopic findings have been accurately detailed by Jaffe and Lichtenstein and the reader is referred to their articles for a classical description of this entity.

TREATMENT: Complete excision of the tumor effects a cure. The disappearance of the pain is dramatic, especially so in long-standing cases. It has been emphasized by others that x-ray control during operation should be utilized to aid in localization and to make certain that the nidus has been completely removed. *Incomplete* removal of the lesion will result in persistence of symptoms, and will necessitate a second operative procedure for relief.

Case Reports

(1) R. R., 19 years, male. The patient was first seen on August 12, 1949 with a complaint of pain in the right knee for six months' duration. There was no history of specific trauma or infection. There was no history of locking or instability of the knee. The initial examination revealed slight painful limitation of flexion of the right knee. X-rays of the right knee revealed the articular surfaces of the femur, tibia, and patella to be smooth and regular with the exception of a small area approxi-



Figure 1

R.R. X-ray of right knee August 12, 1949. Patient had complained of pain for six months. Diagnosis of probable osteochondritis dissecans was made. The osteoid osteoma in the posterior portion of the right lateral femoral condyle was not clearly evident.

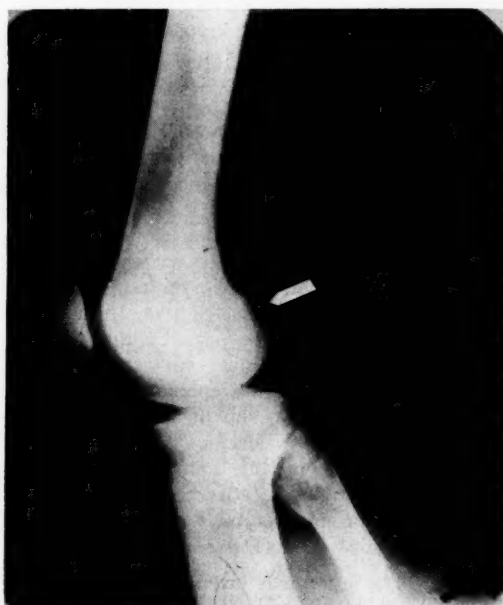


Figure 2

R.R. Right knee April 3, 1950. The osteoid osteoma is now clearly evident. The nidus is circumscribed by a zone of decreased density in the posterior portion of the right lateral femoral condyle.

mately $\frac{1}{4}$ " in length on the lateral border of the femoral condyle. There was a fine irregular fissure demarcating this corner which suggested a very early osteochondritis dissecans in this region. The remainder of the bones were normal in texture and contour. No calcification was seen about the joint. A diagnosis of probable early osteochondritis dissecans of the outer portion of the lateral femoral condyle of the right knee was made. The patient was advised to wear an elastic knee support and rest the knee. The patient continued to complain of pain and one month later a plaster of Paris cylinder was applied immobilizing the left knee. The cast was worn for one month and following its removal x-rays of the right knee in the anteroposterior and lateral views, as well as a tunnel view, revealed that the area of irregularity in the cortical portion of the lateral femoral condyle appeared much improved and the articular surfaces were smooth. The patient was advised to wear an elastic bandage and was instructed in quadriceps exercises. The patient was given physiotherapy and appeared to be improved, regaining the full range of motion of the right knee by January, 1950. He was not seen for several months and returned in March, 1950, complaining of pain in the lateral aspect of the right knee and intermittent swelling. X-rays taken on April 3, 1950 revealed a small area of localized circumscription in the posterior portion of the right lateral femoral condyle which was suggestive of an osteoid osteoma. The remainder of the knee joint was normal throughout. The patient was admitted to the Rhode Island Hospital and on April 13, 1950, under x-ray control, the osteoid osteoma was removed by block excision. The block of bone on examination grossly showed a small, demarcated, pea-sized core which did not appear to invade the surrounding bone. This nidus measured about $\frac{1}{4}$ " in diameter. Its center was composed of cancellous, dark red bone. The postoperative course was uneventful and the patient made an uneventful recovery, stating that the pain had completely disappeared the day following the operation.

Pathological diagnosis was osteoid osteoma.

The patient has been asymptomatic since.

(2) D. P., 20 years, male. This patient was first seen in June, 1947, with complaint of pain down the ulnar side of his right forearm of two-to-three weeks' duration. He recalled no antecedent trauma or infection. X-rays of the right elbow were essentially negative. A diagnosis of recurrent mild subluxation of the right ulnar nerve was made. The patient was advised to wear a splint and apply heat locally. He improved somewhat, but returned in September, 1947, again complaining of pain. At this time he was given physiotherapy in the form of diathermy, histamine iontophoresis and, in

addition, was given thiamine chloride by mouth. The patient was never completely relieved of his pain and in February of 1948 a cast was applied

continued on next page



Figure 3

R.R. The X-ray taken in O.R. April 13, 1953 illustrates the need for X-ray control. The nidus is seen distal to the lower drill point. Failure to remove the lesion completely may necessitate a second operation.



Figure 4

R.R. X-ray (O.R. April 13, 1953) following block excision reveals complete removal of the osteoid osteoma.

extending from the elbow to the knuckles in the cock-up position. This was maintained for four weeks, during which time, the patient received heat and physiotherapy to his elbow. The patient was seen again in October, 1948, at which time, there was definite restriction of motion of the right elbow. Angle of greatest extension was 165 degrees, angle of greatest flexion 40 degrees. Rotation of the forearm was markedly restricted, pronation being possible to 45 degrees and supination being possible to 10 degrees. At these points, the patient complained of definite pain in the region of the radial head. X-rays, at this time, revealed the articular surfaces of the humerus, radius and ulna to be smooth and regular. There was moderate osteoporosis of the radial head and neck as well as of the contiguous portion of the lateral humeral condyle as compared with the surrounding bones and the previous x-rays of June, 1947. No soft tissue calcifications were noted.

Because of the restriction of motions of the elbow, the patient was advised to perform active stretching exercises which he did with some improvement. However, the pain did not completely disappear and in March, 1949, the patient was seen in consultation by Dr. Frank Ober of Boston. Dr. Ober reviewed the x-ray and noted the decrease in density between the head of the radius and the sigmoid process. He also noted atrophy of the radius and increase in density of the ulna especially the upper end. He recommended that a biopsy be done between the radius and ulna, with guinea pig inoculation. This was performed on April 2, 1949 and the pathological report was that of chronic inflammatory tissue from the right elbow. The guinea pig inoculation was negative. The smear and culture were negative. Postoperatively the patient gradually regained motion of his elbow, but continued to have pain. The only relief was ob-



Figure 5

D.P. X-ray right elbow, June 3, 1947. Patient had complained of pain in right elbow for three weeks. No history of trauma or infection. X-rays were reported as negative for bony or soft tissue pathology.



Figure 6

D.P. Right elbow — October 16, 1948. Patient unrelieved of pain. Restriction of motions, especially rotation now present. Osteoporosis of lateral humeral condyle noted. There is now noted the earliest suggestion of sclerosis within the proximal ulna.



Figure 7

D.P. Right elbow October 1, 1949. Biopsy had been performed April 2, 1949 which revealed chronic inflammatory reaction non-specific. Guinea pig inoculation was negative. At this time sclerosis of the proximal ulna was quite evident and a diagnosis of osteoid osteoma was now considered.



Figure 8

D.P. May 13, 1950. Three months postoperative. Patient made uneventful recovery and had painless motions of the elbow.

tained with the use of local heat and aspirin. X-rays of the elbow taken on October 1, 1949 again revealed moderate osteoporosis of the lateral humeral condyle and the proximal end of the radius and slight increase in density of the proximal ulna. The patient was again seen by Dr. Ober on November 4, 1949, and at this time it was Dr. Ober's suggestion that we were dealing with an osteoid osteoma.

The patient was admitted to the hospital and on January 28, 1950 excision of the osteoid osteoma of the right upper ulna and excision of the head of the radius performed. At operation the proximal end of the ulna presented a large, irregular, bony mass 1" long just below the coronoid process. The bony mass extended across the interosseous space jutting against the head and neck of the radius by physical contact. The entire bony mass was excised including the contiguous portion of the ulna. The bone mass was then split and a questionable nidus, reddish in color, was noted in the central portion of the very dense hard bone.

The pathological report failed to reveal the nidus, but the dense cortical bone described previously was present.

The patient made an uneventful postoperative recovery and stated that the previous gnawing pain had disappeared the day following the operation.

(3) G. C., 17 years, male. The patient was seen in June, 1951, with the complaint of an annoying pain in his left hip region radiating down the anterior aspect of the left thigh for the past three years. He had been treated for the past two years by another physician with a diagnosis of "Perthes' disease." The patient stated that aspirin afforded definite relief of his pain. He stated that his pain was not relieved by bedrest as he had had an appendectomy one year previously, at which time, he spent approximately three weeks in bed.

Examination revealed mild atrophy of the left thigh and calf and slight limitation of motion of the left hip region.

X-rays of the pelvis and left hip revealed on the inner cortex of the neck of the left femur an area of sclerosis with a surrounding zone of radiolucency compatible with an osteoid osteoma. The patient was admitted to the Miriam Hospital and on August 13, 1951, under x-ray control, the osteoid osteoma was removed by block excision. The histological appearance of the lesion was typical of an osteoid osteoma. Clinically there was a small cherry-red nidus surrounded by a zone of sclerotic bone.

The postoperative course was uneventful, the patient stating that the pain had completely disappeared on the day following the operation. He

made an uneventful recovery and has had no complaint of pain in his left hip since.

continued on next page



Figure 9

G.C. Left hip—June 27, 1951. Pre-operative film — on the inner aspect of the neck of the femur there is an area of sclerosis with a circumscribed radiolucent zone.



Figure 10

G.C. Three months postoperative. Patient asymptomatic. The drill holes around the site of the lesion are still evident.

(4) D. H., 35 years, female. This patient noted the onset of dull pain in her left knee approximately four years prior to her visit on October 7, 1952. She stated that she was advised by her local physician that this was probably due to varicose veins following the delivery of her child. She continued to have a dull, aching pain which gradually became worse and she was seen because of a history of injury to her knee several months prior while on a summer vacation.

She stated her knee was swollen, but that the swelling gradually subsided. She has had marked increase in pain since. There was no locking or instability.

The examination revealed little findings other than tenderness on pressure over the medial condyle of the left femur. Motions of the knee were not restricted. The extreme of flexion was painful, however.

X-rays of the left knee in the anteroposterior, lateral and tunnel views revealed an area of increased density in the cortex of the left femur proximal to the condyle, 1cm. in its length and $\frac{1}{2}$ cm. in depth.

The patient was admitted to the Miriam Hospital and on October 14, 1952, under x-ray control, a block excision of the suspected tumor was performed. Clinically, this was dense sclerotic bone and on splitting the bone a nidus was not revealed. The pathological report failed to reveal a nidus, again revealing dense sclerotic bone.

The patient made an uneventful postoperative recovery and stated that her pain had disappeared following recovery from the anesthesia. She was discharged with complete motions of her knee and evidence of filling in of the site of the tumor by x-ray four months following the operation.

(5) E. P., 19 years, female. (The x-rays in this case have been lost, but these were typical of an osteoid osteoma.)

This 19-year old secretary had pain in her left leg for approximately one year prior to admission to the Rhode Island Hospital in September, 1947. She had dull pain which had become progressively worse. She recalled no antecedent trauma or infection.

X-rays taken at the Rhode Island Hospital on September 8, 1947 revealed "an expansion of the midportion of the tibial cortex of the left leg extending over a longitudinal distance of approximately $3\frac{1}{2}$ cm. The maximal thickness was 1.3cm. with considerable anterior bulging in the midportion. About 2 mm. below the surface of the bulge, a faint, oval area of rarefaction can be seen on the over exposed film measuring approximately 9×4 mm., and an additional much more oval fleck just below it. The medullary region shows a mini-

mal amount of increased density above and below the level of the cortical thickening.

"Conclusion: The appearances are consistent with localized osteoid osteoma" (Report of Dr. G. Martineau).

The patient was seen by one of us (C.M.S.) in orthopedic consultation and excision advised. This



Figures 11a and 11b

D.H. X-rays of left knee, October 27, 1952. This patient had pain in knee for four years and told it was due to varicose veins.

was performed on September 24, 1947 and a block excision of the tumor was performed. On splitting a section of the bone longitudinally two soft central cystic areas were seen which coincided with the areas observed on x-ray.

The pathological diagnosis was osteoid osteoma of the tibia.

The patient made an uneventful recovery and stated the pain in the leg was completely gone. She appeared much happier as contrasted to a marked depression noted preoperatively. There has not been any recurrence of pain since the date of the operation.



Figure 12

D.H. X-ray (O.R. — October 14, 1952). The lesion is clearly outlined by the drills. A block dissection was then performed.

SUMMARY

1. Five cases of Osteoid Osteoma have been presented: — three males, two females. Ages 17, 19, 19, 20, 35.

2. In three cases diagnosis was confirmed by microscopic examination. In two instances, the nidus of osteoid was not revealed and only a dense area of sclerotic bone was seen.

3. All cases were cured by block excision of the tumor under x-ray control.

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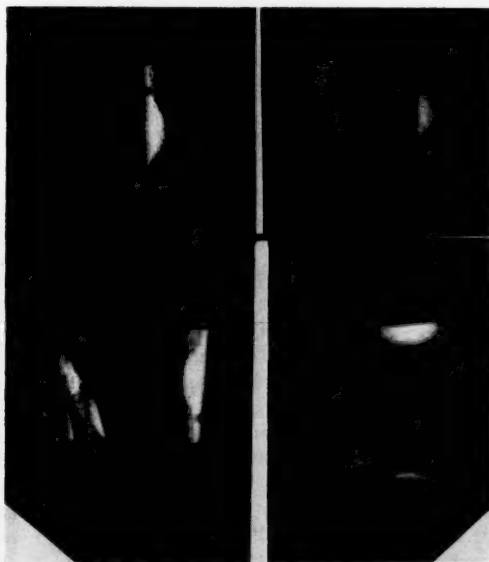


Figure 13

D.H. X-ray of specimen revealing dense sclerosis with no evidence of a nidus in the split sections.



Figure 14

D.H. February, 1953 (four months postoperative). Patient is asymptomatic. There has been filling in at site of block dissection. Osteoporosis is still evident.

PSYCHIATRIC PROBLEMS ASSOCIATED WITH THE AGING*

LAURENCE A. SENSEMAN, M.D.

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MUCH HAS BEEN WRITTEN in recent years regarding geriatrics. Something very important has happened to prompt such an interest, especially among psychiatrists. This is because of such a rapid increase in mental illness in this period of life. In the past 15 years, the number of aging people has increased out of proportion to any of the other personality disturbances. There has been a definite shift in the state hospital population towards this age group. For instance, in the State of Rhode Island in 1900, there were 4.6% of our population over 65. In 1950, there were 8.9% of our population over 65. One-third of these were over 75. In total figures, this would represent 70,400 over 65 in a population of 791,900 or a 256% increase since 1900 in this age group. Of this group of 70,400 there were 13.3% in hospitals. In our State Hospital population, one-quarter or 975 of the patients are over 65.¹ Compare this with the mental hospital picture as a whole in the United States—one-third are over 60.

Of further interest, are statistics taken from a recent A.M.A. JOURNAL.² In 1934, there were 614 mental hospitals caring for 488,481 patients; in 1952 there were 585 mental hospitals taking care of 704,056 patients. In 1952, there were 4,924 general hospitals caring for 475,193 patients with an additional 550 special hospitals caring for approximately 80,000 patients. Also of interest is the fact that in 1952, there was an estimated 10½ million people over 65 years of age and the estimated figure for 1960 is 14 million.

Now let us compare this with the State of Virginia.³ Those over 65 years of age in 1940 increased 32% over 1930; and in 1950, an increase of 38.5% over 1940. Of first admissions to mental hospitals, there was an increase in 1950 of 61% over 1940; whereas, the population increase was 45% of the same group. Therefore, the importance of these statistics should become more apparent to us.

*Read before the Rhode Island Mental Hygiene Society, at Providence, Rhode Island, October 26, 1953.

What are the causes or the etiological factors of breakdown in this age group? Age of itself does not necessarily mean mental illness as recently brought out in the AMERICAN JOURNAL OF PSYCHIATRY.⁴ A man, 106 years of age, who was free of any dementia despite his advanced age, on detailed study was found to be of high intellect, endowment, and good emotional resources. This particular article showed that strong ego resources play a definite role in resisting the onset of a dementia, even in advanced years. Even on microscopic or histological examination, changes of a severe nature may be found in people who show absolutely no psychotic type of reaction. Then again, those who do show psychotic reactions may show little or no histological changes.

This points out the fact that there are other factors involved, such as the personality make-up of the individual and the socio-psychological stress situations developed in this period of life. It has been pointed out in the involutional type of psychotic patients, that limited interests have constricted them in a "time-bound" attitude.⁵ That is, they may remain productive up to a certain time or to the completion of certain objectives, and then they are unable to shift to some different interests or hobbies or activities; they reach an impasse, and then hopelessly fail in their adjustment to their environment. This is especially true in this particular age group where some catastrophic stress situation is precipitated by the death of a loved one, or financial reverses, or the loss of a position, or the like. It is also true that in this age group, the physical changes which occur in the body may make a person less able to handle the problems with which he is confronted—wear and tear of the physical body, infections, toxicity. Also changes in the body chemistry and metabolism play a part. With these physical changes come psychological reactions to them, creating fertile ground for a mental illness.

I also want to point out that emotional changes are often associated with such important factors as retirement from work which has always absorbed a major part of the patient's interest and attention. This may produce pronounced effects on his morale. If he is not prepared to retire to new interests and

continued on page 34



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PSYCHIATRIC PROBLEMS ASSOCIATED WITH THE AGING

continued from page 30

associations or to a fuller pursuit of his hobbies, he feels that time hangs on his hands and he becomes restless with unexpendable energy and dissatisfaction. He may become worried, concerned, and compulsive over trivial matters, and putter over small jobs. With a decreased income, he worries over financial matters. And with a gradually decreasing circle of friends and acquaintances, he takes a greater interest in the obituary columns. He may become moody, depressed, irritable, and even jealous of those about him. Because of his increased sensitivity, he may have quarrels with members of his family and certain suspicions often arise in believing that people do not like him or are working against him. As they grow older, with more time for introspection, they may become more religious and philosophical and this is a healthy attitude.

While in Los Angeles recently, attending the American Psychiatric meeting, I was interested in several papers on religion in psychiatry. One paper pointed out that this age group was not increasing in numbers in church attendance; in fact, it was dropping off. This article stated that the church had little to offer the elderly person, as most church activities center around youth. This is one area that can be and is being improved upon.

With increasing age, the patient becomes more and more aware of his physical complaints, especially of his decreasing acuity of the sense organs, such as hearing and vision. He also becomes more sensitive to weather changes and food idiosyncrasies. These complaints are frequently multiplied to gain the sympathy of those in his environment. Elderly persons frequently regret the changes of custom and have no interest in accepting new ones. With these feelings of inadequacy, it makes the patient increasingly dependent upon the advice and attention of others, and many have been taken advantage of by strangers who are looking for their own gain.⁶ They may respond to their anxieties, worries, and fears by developing signs of definite organized mental illness. These may be mild at first and of a psychoneurotic nature, and then later may reach psychotic proportion. It is not unusual to see the involuntal type of psychosis, and even the manic depressive types of illness, with repeated episodes of mood swings which are usually found in the earlier years of life. Even schizophrenic patients reach this age group and it is often recognized in the aging.

A recent article in the *AMERICAN JOURNAL OF PSYCHIATRY*⁷ states: "It has been found repeated-

RHODE ISLAND MEDICAL JOURNAL

ly that emotional disorganization often exaggerates a picture of brain damage and makes for the mistake and belief that treatment will be futile." Many patients who, after cursory examination, might be passed as a confused or senile individual, were found, on psychiatric examination, to be psychoneurotic in the absence of significant degrees of brain damage. It, therefore, would seem worth while to give all cases of disordered behavior in aging people a trial of treatment which brings us to the all-important problem of what can be done for the aged who are showing evidence of mental illness?

In an article of the *JOURNAL AMERICAN GERIATRICS SOCIETY* in June, 1953,⁸ there was a series of 20 patients from 60 to 82 years of age, 18 of whom were given insulin and/or shock treatment. They were given from 4 to 29 electric shock treatments and an average of 12 shock treatments each. Seven patients had insulin without shock treatment and 11 received a combination of insulin and shock treatment. Fifteen of the patients made an occupational grade recovery and four made a social grade recovery. Six patients relapsed but, with retreatment, regained their previous grade of recovery. The article also pointed out that this type of illness frequently ended in death in the days before insulin and electric shock were used in mental disorders. I quote, "We think the addition of insulin and electric shock therapy has greatly improved the prognosis in some of the geriatric patients with mental disorders."

Another article from the same magazine in May of 1953⁹ points out that satisfactory results can be expected when proper treatment is applied to selected cases. Six patients over 80 years of age are discussed and these were seen in one or more attacks of mental illness which were considered to be functional. Treatment results with convulsive shock therapy confirmed this viewpoint. The article also pointed out that patients from any age group can be given shock therapy safely, provided that satisfactory physical studies are made in advance and clearance is given by a competent internist who is experienced in the side effects and complications of such therapy.

In my own experience, it is interesting to note that incompetent psychotic persons may rapidly become competent after electric shock treatments. I am thinking particularly of a patient in a nearby community whom I saw in consultation, the question being admission to the State Hospital. She apparently was depressed and suspicious, but after a short period of electric shock treatment, she made a complete recovery. Another patient, age 79, who had been depressed over a period of 20 years, responded to electric shock treatment. While these

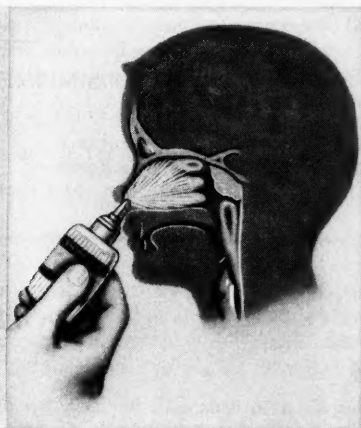
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Owned and Published Monthly by the Rhode Island Medical Society
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POLIO VACCINE

A RHODE ISLAND area will be included in the nation-wide study to determine the effectiveness of the Salk polio vaccine, according to preliminary plans worked out during the past month under the direction of the state director of health. The Salk vaccine, developed by Dr. Jonas E. Salk, research professor of bacteriology at the University of Pittsburgh, is composed of killed virus of all three polio virus types which have been grown in test-tube cultures of monkey kidney tissues. The virus will be an aqueous type, distributed in disposable syringes.

The nation-wide test will be on second grade children, and the basic factor for determining the protective effects of the vaccine will be a comparison of the incidence of paralytic polio in the vaccinated group with that of children in the first and third school grades. Some half million to a million children will be tested, dependent upon the funds available and the quantity of the vaccine prepared within the next five months.

General safety aspects are receiving very careful consideration. The vaccine will undergo the same test by the manufacturer, by Dr. Salk's staff, and finally by the national control laboratory of

the National Institute of Health. If negative results show in any of these three tests the particular batch of vaccine will be discarded. And if any unexplained illness occurs the field trial will be halted in that area immediately and an expert team of investigators will move in for a checkup.

Each child to be tested is slated to receive three injections of 1 cc each of the vaccine, the first two doses at weekly intervals, and the third or "booster shot" four weeks later. Local physicians in the area where the test will be conducted—the site is determined by the National Foundation for Infantile Paralysis—are counted upon to volunteer their services for the task of injecting the vaccine in the grade pupils on the respective "V" days. The local polio chapters will not pay for any personal services of physicians in connection with the field trial, according to the Foundation.

The tests will start in the southern states in February, and all areas of the country involved in the test will complete their work by June 1. The results will not be known until comparative data are reviewed and studied, with a final report possible some time in 1955.

So far the testing by Dr. Salk in the Allegheny

County (Pittsburgh) area of 700 school children has indicated that the antibody level has remained consistently high. How long it will last is problematical, but the indication is most favorable for a long-term immunization.

With the projected field trial in the country estimated to cost better than seven million dollars, the campaign for polio funds through the March of Dimes campaign this month takes on added significance. Physicians may be of great service in conveying to patients the significance of this vaccine test, and in urging the additional financial support that must be forthcoming to guarantee that the test may be nation-wide, and all inclusive. Disease is no respecter of state boundaries, and therefore every area should be involved in the vaccine validity study of 1954.

HOSPITAL ACCREDITATION

The action of the AMA House of Delegates at the St. Louis interim session last month in requesting the Joint Commission on Accreditation of Hospitals to report by an article, or series of articles in official medical publications on its regulations and method of appeal to its decisions is a step in the right direction.

The lack of general knowledge on the working of the Commission has caused misunderstandings among physicians. The AMA resolution seeks a clarification of the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement. The by-laws of the Commission point out that a hospital may appeal a decision of the Commission by writing a letter to the Commission setting forth its differences, and the Commission in turn guarantees a "fair" hearing of the grievances by representatives of the aggrieved party before the Committee or a representative committee of it.

It is understood by some that additional ways to appeal would be through the standing committee on Medical Education and Hospitals of the AMA who in turn would refer it to the Council on Medical Education and Hospitals, and also through resolution adopted by a county medical society, thence by a State Society House of Delegates to be placed in turn before the AMA house of delegates.

A complete delineation of all the rules of procedure, and a clarification of the handling of grievances should be undertaken promptly. We feel certain that every medical publication will be glad to allocate space to report the information thus distributed.

MEDICAL-PHARMACEUTICAL FORUM

We have held joint meetings with the dental profession, the bar association, and nursing groups.

Recently the Society's committee on medical-pharmaceutical affairs co-sponsored a meeting with the pharmacists and our membership that was highly successful in resolving, or at least bringing pointedly to the forefront, causes of grievance between the two professional groups.

The grievances were presented in questions offered by physicians and pharmacists in a written poll prior to the forum meeting. There was no dodging of issues, and errors of commission or omission were readily admitted by spokesmen of both sides. Counter-prescribing, encouragement of self-diagnosis and self-prescribing, telephoned prescriptions, refills, drug cost misunderstandings—all came in for review and discussion.

The evening was certainly productive of a better understanding of common problems met by the individual physician and pharmacist that might well be resolved through a set of rules jointly adopted by both the medical society and the pharmaceutical association. We hope that the respective inter-professional relations committees will develop a list of the "do's" and "don't's" for distribution to both our memberships based on the discussions at the recent forum.

PUBLIC REACTION

Our literature today contains frequent reference to PR, which is submitted as an abbreviated way of saying "Public Relations." By equal connotation PR may well be interpreted to mean "Public Reaction." And if the public reacts favorably we may assume that our public relations are in fine form.

We doubt very much that when Dr. Michael Scanlon of Westerly started practice in 1900 he concerned himself with medical public relations in the way the high-pressured agents of the spoken and written word now concern themselves in their efforts to tell physicians, as well as those in all other vocations, how to maintain good relations with their neighbors.

Dr. Michael Scanlon merely did what came naturally—he started in being a good neighbor, and he practiced it all his life, with his friends and with his patients, and the two are synonymous after you have rendered faithful, unselfish and conscientious service, day and night, over a span of years. The public reaction to Dr. Scanlon has always been one of deep admiration, respect and love, and it was all nicely crystallized in simple form last month when some of his many friends honored him on his seventy-eighth birthday. You read about the event in RIMScope, the publication of our Committee on Public Policy, but the significance of the testimonial warrants reiteration.

For the doctor just starting practice, or still in his first years of medical service, the statement of

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one of Dr. Scanlon's patients, as quoted in the press account, that "he remembered us when we needed him in sickness for so many years, and we thought that this would be a small token of appreciation," sums up a public reaction to good medical practice that millions of dollars of paid advertising by every known modern medium could not achieve. And an equal amount of money for worldly goods could not bring a greater pleasure and satisfaction to Dr. Scanlon than the generous gift of affection of his patients and friends.

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The announcement that the Rhode Island Medical Society Physicians Service enrollment has approached the four hundred thousand mark is eloquent tribute to all-round community teamwork in Rhode Island.

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On the occasion of the start of its fifth year of operation, the participating physicians who have guaranteed the success of Physicians Service have reason to be justifiably proud of their achievement in the field of health insurance.

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physical treatments are of value, one must not overlook the importance of psychotherapy, diet, increased recreational activities, and occupational therapy.

If one is to accept the thesis that the personality structure of an individual is the result of his inherited traits and early conditioning experiences, then it should follow that a systematic control of these early experiences by proper educational methods can be of great value in developing personality patterns which will render the individual better prepared to meet the vicissitudes and stresses in old age. It is on this basis, that a program of mental health for the aging can be successfully organized. Also, investigation of the cause and nature of physical and mental changes will certainly lead to a decrease of these factors. We all recognize that there is a discrepancy in medical progress as compared with social organization. Along with our increase in life expectancy, the social organization has not provided the opportunities for the aging. Thus, with more elderly people and less opportunity for occupation, they lose their sense of security and self-respect. It is the duty and privilege of society in general to provide conditions under which these added years will bring with them, not only longer existence, but active and well adjusted lives for those of our aging population.¹⁰

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Menthol	1.0 mg.
Chloroform	0.0166 cc.
Alcohol	8%

*Exempt narcotic

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Adults—1 or 2 teaspoonfuls every two to four hours, not to exceed 5 doses in twenty-four hours.

Children 6 to 12 years—½ to 1 teaspoonful four or five times daily.

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AMA DELEGATE'S REPORT

INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION

*At St. Louis, Missouri, December 1-4, 1953*CHARLES L. FARRELL, M.D., *Delegate*

THE HOUSE of Delegates of the American Medical Association in the Seventh Annual Clinical Session made important decisions on such subjects as social security, voluntary health insurance, medical ethics, unethical practices, medical education, hospital accreditation, and military affairs. It selected Dr. Joseph I. Greenwell of New Haven, Kentucky as the General Practitioner of the Year.

The Annual Reports of the Secretary and General Manager were approved as also were the Reports of the Board of Trustees and the Standing and Special Committees. A detailed report on the action of the House can be found in full in the JOURNAL of the A.M.A. Vol. 153 — Nos. 17 and 18 — issued December 26, 1953 and January 2, 1954.

The House reaffirmed its opposition to compulsory coverage of physicians under Old Age and Survivors Insurance program and advocated the passage of the Jenkins-Keogh bills now pending in Congress. These bills eliminate discrimination and inequities that exist under present tax laws by extending the tax deferment privilege to the country's ten million self-employed and to millions of employees not covered by pension plans.

The House also approved continued action to obtain passage of the Bricker Amendment and approved the principle of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes. The House also opposed any further extension of the Doctor Draft Law beyond the expiration date of June 30, 1955.

In the field of Voluntary Health Insurance the House passed a resolution requesting the Council on Medical Service to proceed immediately with a special study of the problems of catastrophic coverage and coverage for retired persons.

One of the basic tenets of Voluntary Health Insurance laid down by the House many years ago and reaffirmed repeatedly, was again emphasized at the St. Louis meeting when the House adopted a resolution that stated, "The American Medical Association condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirmed previous action of the

House defining pathology, radiology, anesthesiology and psychiatry as medical services.

The Iowa State Medical Society introduced a resolution calling for approval of joint billing procedures involving services rendered by two or more physicians which was referred to the Judicial Council with a recommendation that the Judicial Council investigate the factors involved and determine if there are new factors which would cause it to change the opinion determined in 1952.

In reference to problems arising from unethical practices by a small minority of doctors, the House referred to the Board of Trustees a resolution calling for the appointment of a special committee with broad professional representation to study all aspects of the problem. The Board was asked to study and implement the intent of the resolution and report to the House at the June, 1954 meeting in San Francisco.

Because of serious misunderstanding among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, the House adopted a resolution that the A.M.A. request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in the JOURNAL of the A.M.A. and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, by-laws and their interpretation, and that the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement.

The American Medical Association made a fourth grant of \$500,000 to the American Medical Education Foundation for financial aid to the nation's medical schools.

Of particular interest to physicians of Rhode Island were three resolutions introduced by your Delegate. One resolution would abolish the matching plan for internships. The second one would require the republication of the list of accredited hospitals for intern training including the ones not subscribing to the matching plan, and designating them by special asterisk or other device rather than segregating them in a separate list. The third would

require the investigation of the needs of hospitals for the interns they ask for.

Your Delegate was himself a member of the Reference Committee. It was therefore not possible for him personally to introduce the resolutions at the Reference Committee to which they were referred and the Alternate Delegate, Dr. Ashworth, appeared and presented the point of view of the Council of the Rhode Island Medical Society and the attitude of the President, Dr. Earl Kelly, as well as the problems of the Memorial Hospital, Pawtucket.

Your Delegate subsequently appeared before the Reference Committee on Medical Education and Hospitals when his own work was completed and was well received. He was assured by the Reference Committee that the situation had been ably presented by Dr. Ashworth and that they were fully cognizant of the need for change. However, we discussed some further points, and at the conclusion of the hearing the Reference Committee took the following action which was subsequently approved by the House of Delegates:

1. In regard to the abolition of the Matching Plan the Committee felt that sufficient evidence had not been presented to warrant these recommendations at the present time. It was fully aware that hospitals were having difficulty in getting interns even with the Matching Plan, and that there remained some areas in which further study was needed.
2. It therefore concurred with the third resolution and requested a Committee to investigate the reputed needs of the hospitals for interns in relationship to their demonstrated needs and to report at the next Session.
3. The second resolution was looked upon with favor and the Council on Medical Education and Hospitals and the Editor of the JOURNAL were ordered to republish, at an early date, a corrected list of Hospitals Approved for Internship including the hospitals which had not subscribed to the Matching Plan rather than to segregate them in a separate list.

This was an extremely busy session of the House, a great deal of important business was transacted. Attendance at and participation in these meetings took the full time of both your Delegate and your Alternate Delegate and emphasized again the need for more representation from Rhode Island and the smaller states.

In the past your Delegate has attempted to have the delegations from the smaller states increased but without success. Sessions such as this past one very definitely point up the desirability of increased representation and some of our future efforts will begin directed along that line.

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DISTRICT MEDICAL SOCIETY MEETINGS

WOONSOCKET DISTRICT MEDICAL SOCIETY

The Fall meeting of the Woonsocket District Medical Society was held on December 8, 1953 at the Howard Johnson restaurant. The meeting was called to order by the president, Emil A. Kas-kiw, M.D. Minutes of the previous meeting were read and accepted. Election of officers for the ensuing year followed, and elected to office were:

President Dr. Joseph B. McKenna
Vice President Dr. Saul A. Wittes
Treasurer Dr. Paul E. Boucher
Secretary Dr. Euclide L. Tremblay
Censors Drs. Joseph W. Reilly,
Francis J. King, Victor H. Monti
Councillor Dr. Edward B. Medoff
Delegates to the House of Delegates—

Drs. Francis P. Vose, Alfred E. King
Dr. Philip J. Morrison was elected a member of our society.

A general discussion period followed, and a motion was made, seconded, and passed:



JOSEPH B. MCKENNA, M.D., President
Woonsocket District Medical Society

The Woonsocket District Medical Society is in favor of the payment of more equitable pre and post-operative care fees, to whatever physicians that provide these services, whether he is a surgeon, or the referring physician giving post-operative care.

This society also moves to forward a copy of this resolution to the Physicians Service Plan of Rhode Island, the Rhode Island Medical Society, and to each District Medical Society of Rhode Island for their information, comment, and action.

The meeting was closed at 10:30 P.M. and a buffet lunch was served.

Very truly yours,

EUCLIDE L. TREMBLAY, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The December 2, 1953 meeting of The Newport County Medical Society was called to order by President Zielinski at 8:30 p.m. in the Hotel Viking, with 25 members and 6 guests attending. These included Dr. Alex Burgess, Jr., Dr. Thomas Brown, and Dr. Harold Fleischer and Dr. George Burkley of the Naval Hospital.

The minutes of the last meeting were read and approved.

COMMUNICATIONS: The Secretary reported on the Diabetic Detection Drive and urged the members to fill out the state report to the Committee on Diabetes.

The Secretary reported a telephone conversation with Mr. Eddy to the effect that the Physicians Service Blue Cross Drive was highly successful, with approximately 20,000 new applications, with a high percentage from Newport County and in addition approximately 16,000 that were transferred from Brown & Sharpe.

NEW BUSINESS: Dr. Annie Saltzberger Doroff was accepted into membership and Dr. Raymond Trott's application was referred to the Board of Censors.

Dr. Ceppi announced that it is customary to have a children's Hospital Ward party and felt that the Medical Society should sponsor such a project. Dr. Malone moved that \$25.00 be made available to a Christmas Party Committee and if funds are

not available, an assessment to members be made. It was so voted.

On Dr. Carey's motion the secretary was directed to write a letter of cheer to both Dr. Sullivan and Dr. Adelson during their illnesses.

Dr. Grimes brought up for discussion the ethics of using prescription blanks advertising a particular druggist. This was referred to the Public Relations Committee for report at the next meeting.

OLD BUSINESS: The secretary reported that in the matter of physicians' specialty listings in the classified section of the telephone directory, the state committee recommended that no member of the society list his specialty after his name in the classified section of the telephone directory.

The speaker of the evening was Dr. Alex Burgess, M.D., Medical Consultant to the Veterans Administration, Boston; Medical Consultant, R. I. Hospital, Newport Naval Hospital and the Newport Hospital, who spoke on the Golden Menace, The Staph. of Death — Staph. *Pyogenes Aureus*.

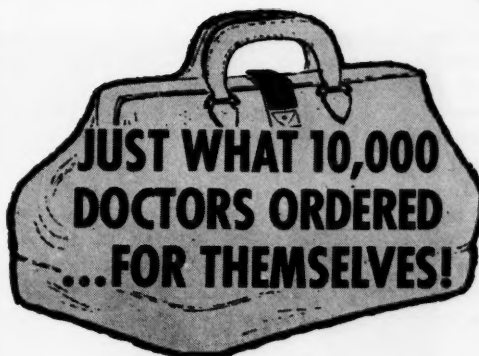
In discussing infections in general he stated that the public frequently demanded the latest antibiotics in the treatment of minor conditions, which resulted in their indiscriminant use and resultant acquired resistance. The bacteriological identification of the organism and sensitivity tests are certainly advisable in hospitalized cases of infection so that specific antibiotic treatment can be given.

In speaking of infections due to Staph. he mentioned their presence in boils, carbuncles, food poisonings, and pneumonia, and that in the past the Staph. septicemia was practically always fatal. He emphasized that ten years ago penicillin was effective in practically all infections. During the course of years the organism has developed an acquired resistance, due to the formation of penicillinase, which resists the action of penicillin. Recent reports show that 80% of hospitalized cases are now Staph. resistant. In 1948 none of the Staph. were resistant to aureomycin. Statistics show 25% are now resistant to aureomycin. Six months ago erythromycin had no resistant strains of Staph., now 30% are resistant.

Three fatal cases of Staph. ileocolitis were reported. All received prophylactic antibiotics, but developed diarrhea progressing to death within the week. He pointed out that the Staph. *Pyogenes Aureus* is a public health problem in hospitals and many pathogenic Staph. can be carried by the nurses, doctors, and attendants (in the nasal secretions) and contaminate other patients.

He separated the antibiotics into groups. The 1st group penicillin, bacitracin, and streptomycin were synergetic and together worked more effectively. Those in group II were terramycin, aureomycin, and chlorophenical were resistant to each other but were synergistic to group I. In group III

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we have erythromycin, which is the latest in a long series of antibiotics. The combination of bacitracin and polymyxin was extremely nephrotoxic and usually not used systematically; however, in very virulent strains of Staph. Aureus, they have been used effectively.

In conclusion he felt that antibiotics should only be used when indicated, so as to prevent breeding an acquired resistant strain of Staph. Pyogenes Aureus.

After an interesting question and answer period the meeting was adjourned at 10 p.m.

Respectfully submitted,

EDWARD ZAMIL, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held October 15, 1953 at the Lindsey Tavern. Twenty-seven members were present.

The minutes of the September 17 meeting were read and accepted.

The applications of Dr. John F. Hogan for active membership and Dr. Leland W. Jones for Associate membership were read and referred to the Standing Committee.

The presentation of these applications evoked considerable discussion as to how new applications should be handled in the future. Dr. Webster suggested that the members have an opportunity to meet and talk with the prospective members before their applications are presented. Dr. Henry Turner echoed the same sentiments. He moved that: The Pawtucket Medical Association should not accept new applicants until they are first investigated by the Standing Committee. Dr. Riemer seconded this motion.

Dr. Albert Gaudet pointed out that the acceptance of applicants is governed by the By-Laws and that if the present screening system is not satisfactory the Standing Committee should be changed.

Dr. Mara suggested that new applicants should

RHODE ISLAND MEDICAL JOURNAL

be introduced either to the Standing Committee or to the membership at a regular meeting before the reading of their applications. This suggestion was approved by Dr. Webster.

Dr. Mathewson expressed his satisfaction with the present system, although he thought it might be an improvement if the sponsors introduced the applicants to the members at a regular meeting.

Dr. Henry Turner withdrew his motion.

Dr. Webster moved that: A procedure be adopted, not necessarily involving a change in the By-Laws, so that the sponsors would invite an applicant to a meeting, before his application is read, so that the membership could form an opinion as to his personal qualifications. The motion was seconded by Dr. Paparo.

Dr. Albert Gaudet requested that the Secretary be directed to bring the applicants to the meeting at which the applications are read.

Dr. Hacking felt that all of these ideas were encroaching on the functions of the Standing Committee.

On a voice vote the Chair ruled that Dr. Webster's motion was rejected.

The motion of Dr. Albert Gaudet regarding the American Association of Physicians and Surgeons, tabled at the September 17 meeting, was brought up for consideration.

Dr. Robert Hayes answered the objections raised by Dr. Riemer and indicated his willingness to explain the functions of the A.A.P.S. members, three of whom (Hayes, Turner and A. Gaudet) were present.

Dr. Gaudet's motion was carried by a voice vote.

With reference to the recent offering of malpractice insurance through Lloyds of London, Dr. Hacking pointed out that Lloyds is not licensed to write insurance in Rhode Island and that this factor should be considered before contracts are signed.

Dr. Zolman announced the forthcoming drive of the Blue Cross-Physicians Service.

Dr. Hayes moved that a committee be appointed to consider putting an advertisement in the newspaper regarding this drive. The motion was seconded by Dr. Mara and carried on a voice vote.

Dr. Mara raised several objections to the present intern matching plan.

Dr. Kelly agreed and moved that: The individual members of the Association should wire the A.M.A. protesting the matching plan and the omission of the Pawtucket Memorial Hospital from the list of the approved matching plan hospitals. The motion was seconded by Dr. Chapman.

Dr. Paparo pointed out that students are being told that in not interning in a matching plan hospital they have little chance to obtain a satisfactory residency. Dr. Mara stated that certain schools

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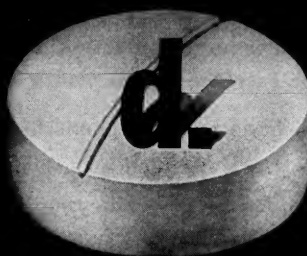
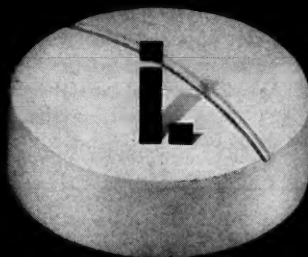
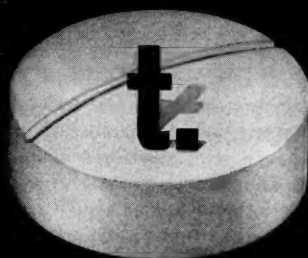
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PAWTUCKET MEDICAL ASSOCIATION

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will withhold the degree of M.D. if the student does not go to a matching plan hospital.

Dr. Kelly's motion was carried on a voice vote.

Dr. Donald Fleming, the guest speaker, present a most unusual and interesting discussion of the activities of Oster, Welch and Kelly at the Johns Hopkins Hospital.

The meeting was adjourned at 10:25 p.m.

Respectfully submitted,

PHILIP J. LAPPIN, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held September 17, 1953 at the Lindsey Tavern with thirty-one members present. The minutes of the last meeting were read and accepted.

A letter from the American Association of Physicians and Surgeons pertaining to the essay prize contest was read. Dr. A. Gaudet moved that our society endorse the activities of the A.A.P.S. and appropriate \$25.00 to help in its activities. Motion seconded. Dr. R. Riemer objected because he felt that the A.A.P.S. overlapped the activities of the American Medical Association and was therefore unnecessary. Dr. A. Gaudet pointed out that one

RHODE ISLAND MEDICAL JOURNAL

of the chief functions of the A.A.P.S. is to oppose socialized medicine.

Dr. E. Kelly requested a poll to determine how many members of our society were also members of the A.A.P.S. One such member was present. Dr. A. Jaworski moved that Dr. Gaudet's motion be tabled for one month. The motion was seconded and approved 13 to 10.

Dr. Zolmian noted with sorrow the passing of Dr. Stephen Kenny, one of our past presidents.

The application of Drs. M. Morris, D. Johnson and A. Jaworski for active membership were approved by unanimous written ballots.

Mr. L. Fessenden of Higham, Neilson, Whitredge and Reid, Insurance brokers, was introduced. He stated that his company was willing to provide malpractice insurance on an individual or group basis through Lloyds of London. After a short discussion the matter was left open for further consideration.

Dr. Frederic Burns presented a very enlightening and interesting discussion of the use of radioisotopes in the detection and therapy of various pathologic conditions.

Meeting adjourned at 10:15 p.m.

Respectfully submitted,

PHILIP J. LAPPIN, M.D., *Secretary*

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RHODE ISLAND MEDICAL SOCIETY — NECROLOGY, 1953

GEORGE A. ECKERT, M.D., a retired Navy captain and Newport surgeon, died at the Naval Hospital on Friday, June 5, 1953.

A native of Newport, Dr. Eckert was born August 10, 1889 and attended public schools there. He graduated from the University of Vermont Medical College in 1914 and served internships at the Rhode Island Hospital, Providence Lying-In Hospital, and the Providence City Hospital. Dr. Eckert also completed a postgraduate course in surgery at the University of Pennsylvania and a general course at the Naval Medical School. He attended numerous foreign surgical clinics and also spent several months at the Mayo Clinic.

During his twenty-nine years in the Navy Dr. Eckert had been chief of surgical services of Naval Hospitals at Newport, Pearl Harbor, Portsmouth, Virginia, and aboard the hospital ships, *Mercy* and *Solace*.

After his retirement from the service in 1945, Dr. Eckert carried on his professional practice at 130 Touro Street, Newport, confining his services to surgery. In 1947 he was appointed to the active staff and also as a senior surgeon of the Newport Hospital, and in 1950 he was chief of the department of surgery. He was also appointed to the consulting staff in 1952.

Dr. Eckert was a Fellow of the American College of Surgeons and the Rhode Island Medical Society. He held membership in the Founder's Group of the American Board of Surgery, the American Medical Association, and the Newport County Medical Society.

TANCREDI GIOVANNI GRANATA, M.D., a leader in Italo-American organizations for many years, died at his home, September 17, 1953.

Dr. Granata was born in New York City, April 11, 1891, but attended elementary schools in Providence. He attended Colby Academy and was a 1916 graduate of Tufts Medical School. He served a year's internship at St. Elizabeth's Hospital in Boston, Massachusetts, and was certified in Rhode Island and Massachusetts in 1916.

His early years of practice were interrupted by World War I in which he served as a captain.

He also served as a resident at the State Hospital

for Mental Diseases and was on the staff of the Miriam Hospital.

He formerly was a physician in the Providence Health Department and at the time of his death was a specialist on the rating board of the Veterans Administration.

Dr. Granata was president of the Italo-American Club of Rhode Island for seventeen years prior to 1937, and was a member of the Providence Medical Association, the Rhode Island Medical Society and the American Medical Association.

HUGH J. HALL, M.D., a former medical director of Rhode Island's cash sickness program, died on June 20, 1953.

Dr. Hall was born in Pawtucket on July 16, 1896. He attended LaSalle Academy and Providence College. After receiving his M.D. from Hahnemann Medical College of Philadelphia in 1930, he served an internship at the Homeopathic Hospital, now the Roger Williams General Hospital, and obtained his license to practice medicine in this state in 1931.

Dr. Hall was the personal physician of former U. S. Attorney General, J. Howard McGrath for many years. He was a member of the State Chiropractic Board having been appointed to that position in 1934 and 1935. In 1943 he was named as medical director of the state's cash sickness program, but resigned from that post in 1949.

Membership was held by Dr. Hall in the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association. He was on the staff of the Roger Williams General Hospital and president of that staff in 1951.

STEPHEN F. HUGHES, M.D., one of Pawtucket's oldest practicing physicians, died at St. Joseph's Hospital, Providence, on March 3, 1953.

A native of Pawtucket, Dr. Hughes received his preliminary education there and attended the College of Physicians and Surgeons in Baltimore, Maryland. He served his internship at St. Agnes Hospital in Baltimore, and then started his fifty-two years of practice in Pawtucket.

Dr. Hughes held membership in the Pawtucket Medical Association, the Rhode Island Medical Society and the American Medical Association.

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WILLIAM W. HUNT, M.D., eighty-five, a life-time resident of East Providence, succumbed at his home on December 18, 1953, after a long illness.

Born in East Providence on April 22, 1868, Dr. Hunt received his elementary education there. He attended Dartmouth Medical School for one year and was graduated from Columbia College of Physicians and Surgeons in June of 1890.

Dr. Hunt served on the surgical staff of the Rhode Island Hospital from 1892 to 1905 and the staff of the Pawtucket Memorial Hospital. He was at one time police surgeon for the town of East Providence and maintained his practice until October of 1950 when he retired.

Dr. Hunt was very active in the Masonic Order and was a past president of the Metacomet Golf Club. He also held membership in the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

STEPHEN ALOYSIUS KENNEY, M.D., former health officer of Cumberland, died at the age of seventy-seven at his home, on September 14, 1953.

A native of Andover, Massachusetts, Dr. Kenney attended elementary schools in Massachusetts and College of the Holy Cross and Villanova College. He graduated from the College of Physicians and Surgeons, now connected with the University of Maryland, in 1899 and was certified to practice medicine in Rhode Island in that year also.

Dr. Kenney maintained the same office on Broad Street in Valley Falls from the time of his graduation from medical school until his retirement in 1950.

He was medical examiner for Lincoln and Cumberland for 20 years and he was named a member of the Blackstone Valley District Sewer Commission by Senator Pastore when the latter was governor.

A past president of the Pawtucket Medical Association, Dr. Kenney also held membership in the Rhode Island Medical Society and the American Medical Association.

STANISLAS A. LAMOUREUX, M.D., a former druggist and physician, died at his home in New Bedford, Massachusetts, on November 17, 1953 at the age of seventy-six.

He was born in Quebec, Canada on June 30, 1877, and received his elementary education there. Dr. Lamoureux graduated from Tufts College of Medicine in 1910 with his M.D. degree and was licensed to practice in Massachusetts, Connecticut, and Rhode Island.

He operated a drug store in New Bedford prior to receiving his degree from Tufts and established his office as a general practitioner there until 1933.

He then moved to Pawtucket and after completing postgraduate work at Harvard Medical School and the Boston Eye and Ear Hospital, specialized in Eye, Ear, Nose and Throat work until his retirement in 1950.

Dr. Lamoureux was an associate staff member of the Memorial and Notre Dame Hospitals and a staff member of St. Luke's Hospital in New Bedford. He was a member of the American Medical Association, Rhode Island Medical Society, Pawtucket Medical Association, and the Massachusetts Medical Society. He also held membership in various Franco-American societies.

JOHN FRANCIS MURPHY, M.D., chief surgeon at the Providence Lying-In Hospital, died August 30, 1953 at the age of fifty-two.

Born in Woonsocket, January 22, 1901, he attended elementary schools there and graduated from Brown University in 1923 with a Bachelor's degree in Philosophy. He received his medical education at the University of Pennsylvania, graduating in 1927, was certified to practice medicine in Rhode Island in 1929, and served internships from 1927 to 1929 at the Rhode Island Hospital and the Providence Lying-In Hospital.

In addition to his affiliation with the Lying-In Hospital, Dr. Murphy was a member of the staffs at the Rhode Island, St. Joseph's, Charles V. Chapin, Roger Williams, and Pawtucket Memorial Hospitals.

He also held the position of instructor in obstetrics at the Harvard University Medical School.

Membership was held by Dr. Murphy in the Providence Medical Association, Rhode Island Medical Society, American Medical Association, American Board of Obstetricians and Gynecologists, New England Obstetrical and Gynecologists Society, and the Doctors Guild of the Thomistic Institute of Providence College.

FRANCIS D. O'CONNELL, M.D., a well-known surgeon in Providence, died in this city on January 9, 1953.

Born in Wakefield, Massachusetts, on November 10, 1894, Dr. O'Connell attended Boston College graduating with an A.B. degree in 1916. He continued his education at Tufts Medical School, but his studies were interrupted by World War I service. He enlisted in the United States Naval Reserve in 1917 and was attached to the Rhode Island Hospital unit stationed at Queenstown, Ireland. He was in active service for four years and was discharged with the rank of ensign.

Resuming his education, he graduated from Tufts Medical School in 1928 and interned at the Rhode Island Hospital.

After acquiring licensure to practice medicine in Rhode Island in 1929, Dr. O'Connell served for a number of years on the staffs of the Rhode Island Hospital, St. Joseph's Hospital, Roger Williams General Hospital, and the Miriam Hospital.

For twenty-four years Dr. O'Connell had maintained his practice at 215 Thayer Street, Providence, with his brother, Joseph C. O'Connell, M.D.

Dr. O'Connell held membership in the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association and the Metacomet Golf Club.

ARTHUR GILE RANDALL, M.D., one of Rhode Island's oldest physicians in active practice before his retirement last July 1, died November 7, 1953, at the age of eighty-two.

He was born in Valley Falls on November 19, 1870, but moved to North Attleboro and graduated as valedictorian of his class from North Attleboro High School in 1888. He received an A.B. degree upon his graduation from Tufts College in 1892 and his M.D. from the University of Pennsylvania Medical School in 1895. He then began his practice that summer in Central Falls.

After changing his office address a few times, Dr. Randall established an office in the Jackson Building in Providence where he practiced for twenty years until his retirement. He also maintained an office at his home in Scituate for twenty-nine years and was former medical examiner for Scituate, Foster, Glocester and Cranston. Although Dr. Randall relinquished these duties when he retired from practice, he still carried on as Scituate health officer, a post he held for twenty years. He also served on the Scituate town council for many years and was its president for many years.

Professionally, Dr. Randall was the first physician to report a case of tularemia in this region.

As Dr. Randall was an ardent sportsman he belonged to the Rhode Island Fish and Game Association, he was a past president of the Narragansett Gun Club, the first president of the Rhode Island Unit of the U. S. Wildlife Federation, and a member of the Audubon Society and the Nooseneck Hill Club.

Dr. Randall held membership in the American Medical Association, the Rhode Island Medical Society and the Medico-Legal Society.

CHARLES FREDERICK SWEET, M.D., a past president and secretary of the Pawtucket Medical Association, died in his eighty-fifth year on October 20, 1953.

Dr. Sweet was born in Cumberland, Rhode Island, and attended elementary schools in Central Falls and Coles Private School in Pawtucket. A graduate of Harvard Medical School in 1894, Dr.

Sweet was certified to practice medicine in Rhode Island in 1895.

He was a former superintendent of Health and city physician of Central Falls, and a former medical examiner in Pawtucket. In 1899 he was appointed a major and surgeon of the Rhode Island National Guard.

Dr. Sweet was on the staff of the Pawtucket Memorial Hospital and was active in Masonic affairs. He held membership in the Rhode Island Medical Society, Providence Medical Association, Pawtucket Medical Association, American Medical Association, Medical Science Club, and the Association of Military Surgeons of the United States.

CHARLES SAMPSON TURNER, M.D., long a member of the Rhode Island Medical Society, died at his home, 31 Hemalin Road, Cranston, on November 9, 1953. Dr. Turner was seventy-five years old at the time of his death.

Born in Providence on September 22, 1878, Dr. Turner attended grammar school here and was a graduate of Classical High School. He received the degree of Bachelor of Philosophy from Brown University in 1901, and continued at Harvard Medical School graduating as a Doctor of Medicine in 1906.

Dr. Turner served an internship at the Long Island Hospital in Boston and was licensed to practice medicine both in Rhode Island and Massachusetts.

Dr. Turner maintained an office on Broad Street for over thirty years, and was also a Providence public school physician from 1917 until his retirement twelve years ago, and served on the staff of the Rhode Island Hospital.

Membership was held by Dr. Turner in the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, Massachusetts Medical Society, What Cheer Lodge, F.&A.M., Providence Royal Arch Chapter, Providence Council, Providence Chapter OES.

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OSTEOPATHY IN NEW ENGLAND*

A Report on the Practice of Osteopathic Healing in the New England States

JOHN E. FARRELL, SC.D.

The Author: *John E. Farrell, Sc.D., Executive Secretary, The Providence Medical Association and The Rhode Island Medical Society; Executive Secretary-Treasurer, Council of the New England State Medical Societies; Recording Secretary, New England Health Education Association.*

Preface

AT THE ANNUAL MEETING of the House of Delegates of the American Medical Association, held in New York City in June, 1953, a report of the special committee of the Board of Trustees on the study of relations between osteopathy and medicine was presented. The report was subsequently published in its entirety in the *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, Vol. 152, pp. 734-740, June 20, 1953.

The House of Delegates voted to accept the majority report of the Reference Committee on Miscellaneous Business which deferred action on the report until the June, 1954, session of the Association. The majority report of the Reference Committee makes the following comments:

"It is our opinion that the committee of the Board of Trustees has made a great contribution in its Study of the Relations Between Osteopathy and Medicine. It is a splendid and constructive accomplishment, and requires complete knowledge, time, and very careful consideration in order that we may make no mistake in our recommendations and deliberations concerning it.

"There are many differences in the types of licensure granted to osteopaths in different states. We would call to your very careful consideration the special committee's recommendations:

"1. That the House of Delegates declare so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing.

"2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to

improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in undergraduate and postgraduate education of doctors of osteopathy.

"3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

"4. That the Committee for the Study of Relations between osteopathy and medicine or a similar committee be established as a continuing body.

"The Board of Trustees also recommends that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?

"It is our present belief that these recommendations are sound, constructive, and demand from the House of Delegates the usual evaluation and support it likes to give to reports of our Trustees. We cannot see any cause for emergency action."

In the hope that a summary of factual information about osteopathic practice in New England may be of assistance to the delegates to the Council of the New England State Medical Societies this report has been prepared.

Number of Osteopathic Physicians in New England

Data supplied by the American Osteopathic Association indicate that there are 709 osteopathic physicians in this region, residing as follows:

*Presented at the Meeting of the Council of the New England State Medical Societies, at Boston, Mass., November 3, 1953.

Maine	215
New Hampshire	24
Vermont	37
Massachusetts	284
Rhode Island	75
Connecticut	74

In the same six states the directory of the American Medical Association (18th edition, 1950) lists a total of 15,285 doctors of medicine, located as follows:

Maine	938
New Hampshire	742
Vermont	569
Massachusetts	8745
Rhode Island	993
Connecticut	3298

State Examining Boards for Osteopaths

The legislative provisions for the state licensure examining boards for osteopathic physicians in New England vary considerably.

In *Maine* and *Connecticut* the boards consist of five osteopathic physicians, and in *Vermont*, three osteopaths. *Massachusetts* has a board of "7 qualified physicians," and it presently consists of six doctors of medicine and one osteopath. *New Hampshire* has five doctors of medicine. *Rhode Island* has a composite board presently consisting of two doctors of medicine and one osteopath, although the law merely stipulates that the appointees be competent to give the examination, and therefore could be all osteopaths if the appointing authority so desired.

Educational Requirements for Osteopathic Licensure

A. Pre-professional

The educational requirements set forth by the states for licensure to practice osteopathy, as reported by the American Osteopathic Association, require two years of college training, which is clarified in some instances by specifying the type of pre-professional work to be done.

Maine requires two years study in a reputable college, if the student matriculated in an osteopathic college after October 1, 1941. *New Hampshire* requires two years college or the equivalent. *Vermont* lists two years pre-professional college education in a recognized college or university. *Massachusetts*, two years of pre-medical collegiate work including physics, chemistry and biology. *Rhode Island*, two years pre-medical education and a certification in the basic science. *Connecticut*, effective in 1947, requires two academic years of 32 weeks each, which course must include the study of chemistry, physics and general biology in an approved college.

B. Professional

All six states require a four-year professional training program for licensure.

In addition, *New Hampshire*, *Vermont* and *Maine* require an internship, the last named state making its rule effective after October 1, 1953.

New Hampshire lists attendance at a "medical school" approved by the board, and all osteopathic schools approved by the American Osteopathic Association apparently qualify. *Massachusetts* stipulates four years of 32 school weeks each year in a legally chartered medical or osteopathic school.

Rhode Island requires an internship only for unrestricted licensure.

The American Osteopathic Association approves only six osteopathic colleges, as follows:

Chicago College of Osteopathy, Chicago, Illinois
College of Osteopathic Physicians and Surgeons, Los Angeles, California

Des Moines Still College of Osteopathy and Surgery, Des Moines, Iowa

Kansas City College of Osteopathy and Surgery, Kansas City, Missouri

Kirksville College of Osteopathy and Surgery, Kirksville, Missouri

Philadelphia College of Osteopathy, Philadelphia, Pennsylvania

continued on next page



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These are the only osteopathic colleges recognized by the New England state licensure authorities.

Practice Rights

Osteopathic licensure in New England has few legislative restrictions. Highlights of the practice rights as established by the laws are as follows:

Maine—The certificate permits the practice of osteopathy "in all its branches as taught and practiced by the recognized schools and colleges of osteopathy, with the right to use such drugs as are necessary in the practice of osteopathy, surgery and obstetrics, including narcotics, antiseptics and anesthetics."

A recent amendment provides that the annual licensure renewal is to be granted only if satisfactory evidence is furnished the board that the licensee has attended in the year preceding at least two days of five hours each of an annual osteopathic educational program devoted to postgraduate instruction and training in osteopathy, surgery and obstetrics approved by the board; and the "board may in its discretion approve courses meeting such standards conducted by the Maine osteopathic association, or its equivalent to the approval of said board, in the year preceding."

New Hampshire—Licensure is under the Medical Practice Act (Chapter 250, Rev. Laws of New Hampshire, 1942) and it permits unrestricted license to engage in the practice of medicine.

Vermont—The license is unrestricted "to practice osteopathy, surgery and obstetrics in any county of this state without limitation as to manner of therapy." A 1951 amendment provides that persons already licensed may continue in practice except that "no such persons shall practice major surgery who have not successfully passed courses of study aggregating 36 months in a school or schools of osteopathy, approved as herein provided, and in addition, have completed an internship, postgraduate course, of at least one year's duration and acceptable to the board, or have served as surgical assistant for at least one year, which service is acceptable to the board."

Massachusetts—The license granted in Massachusetts is unrestricted, and the law states "the provisions of this chapter (Chapter 112, Vol. IV) with reference to medicine and its practice shall apply to and include osteopathy and its practice . . ."

Rhode Island—A certificate to practice osteopathy in Rhode Island confers "the right to practice osteopathy in all its branches as taught and practiced in recognized colleges of osteopathy. The holder of such certificate shall have the same registered with the clerk of the city or town wherein he resides; he thereby becomes a registered physician,

subject to the same duties and liabilities and entitled to the same rights and privileges which may be imposed by law or governmental regulation upon physicians of any school medicine, *except the practice of major surgery*; provided, however, that any holder of a certificate to practice osteopathy who can satisfy the division of examiners that he has completed one-year postgraduate internship in a hospital approved by said division, may be granted a license to practice any branch of surgery."

Connecticut—License to practice osteopathy in Connecticut is undefined, but a candidate must qualify in "an examination which shall include the subjects of anatomy, physiology, pathology, gynecology, obstetrics, biochemistry, surgery, public health, pharmacology and materia medica, diagnosis, therapeutics, osteopathic medicine and such other branches as are deemed advisable by the board and are taught in colleges or schools of osteopathy approved by the board, provided each applicant shall be notified in advance of the subjects in which he is to be examined."

Any osteopathic physician licensed to practice osteopathy is entitled to take an examination in medicine and surgery given by the Medical Examining Board, and if he passes it successfully he is entitled to unrestricted license to practice medicine and surgery. Less than fifteen are reported to have so qualified.

* * *

In all the New England States osteopathic physicians are reported as registering under the Harrison Narcotics Law where the state licensure permits the physician to dispense or prescribe drugs.

Osteopathic Hospitals

The Bureau of Hospitals of the American Osteopathic Association inspects hospitals, evaluates and makes recommendations to the Board of Trustees which makes final decisions. Hospitals are "registered" if they meet certain minimum standards, and "approved" if they meet required standards for formal training programs for interns and/or residents.

Osteopathic hospitals to be *registered* must be so organized, equipped, staffed and administered as to provide adequate professional care for patients hospitalized therein on a continuous twenty-four (24) hour basis. There must be a minimum of six adult beds available for the care of patients.

Osteopathic hospitals approved for the teaching of interns must have a minimum of twenty-five (25) adult beds, utilized for the care of patients. A bed occupancy of fifty per cent (50%) must be maintained. There must be at least ten adult patient beds for each intern receiving training in the hospital.

continued on page 54

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Literature available on request. Write Medical Service Division, Ciba Pharmaceutical Products, Inc., Summit, N.J.

1. SIMON, S. W.: ANN. ALLERGY 11:218, 1953. 2. KESTEN, D. H.: ANN. ALLERGY 6:408, 1948. 3. LOEW, E. R.: MED. CLIN. N. AM. 34:1351, 1950.

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OSTEOPATHY IN NEW ENGLAND

continued from page 52

The nursing staff for both hospital classifications is on the basis that a sufficient number of nurses to meet the hospital requirements shall be employed, and the supervisor of nursing personnel must be a graduate nurse registered in the state in which the hospital is located.

All registered and approved hospitals must be designated as osteopathic hospitals by the use of the word "osteopathic" in their title or by the use of a subtitle, "an osteopathic institution," prominently displayed on the exterior of the building so that the subtitle is distinctly visible on the main approach to the hospital.

Other minimum standards and requirements for both hospital classifications are published in detail by the American Osteopathic Association.

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Osteopathic Hospitals in New England

There are no osteopathic hospitals in *New Hampshire* or *Connecticut*. Two non-registered hospitals are reported in *Vermont*, neither of which qualifies as a general hospital.

In *Maine* there are three hospitals registered for the training of interns (two of which also qualify for resident training, as noted below); one registered hospital, and three non-registered hospitals.

In *Massachusetts* there is only one hospital, and it is approved for resident and intern training.

Rhode Island has one general hospital classed as a registered hospital.

These hospitals and their bed capacities, are as follows:

<i>Maine</i>			
<i>Approved</i>	<i>Beds</i>	<i>Bassinets</i>	<i>Intern and Resident Training</i>
Bangor Osteopathic Hospital.....	39	6	1 Roentgenology 1 Surgery
Osteopathic Hospital of Maine (Portland).....	60	8	1 Anesthesiology 1 Internal Med. 1 Roentgenology 1 Surgery
Waterville Osteopathic Hospital.....	33	6	Approved for intern training
<i>Registered Hospitals</i>			
Saco Osteopathic Hospital (Saco).....	24	6	None
<i>Non-Registered Hospitals</i>			
Harbor Osteopathic (York Harbor).....	35	8	None
Lincoln Hospital (Lincoln).....	30	10	None
Camden-Armstrong (Obs.) (Camden).....	4	4	None
<i>Massachusetts</i>			
<i>Approved</i>			
Massachusetts Osteopathic Hosp. (Jamaica Plain).....	65	12	1 Obs. Gyn. Surg. 1 Surgery
<i>Rhode Island</i>			
<i>Registered Hospital</i>			
Osteopathic General Hospital of Rhode Island (Cranston)*	38	12	None
(*Census based on the capacity of new wing scheduled for completion before November 15, 1953.)			
<i>Vermont</i>			
<i>Non-Registered Hospitals</i>			
(A private sanitarium in Lyndonville).....	(No record of bed capacity)		
(A private sanitarium in Orleans).....	(No record of bed capacity)		

SUMMARY

- 4 approved hospitals
- 2 registered hospitals
- 5 non-registered hospitals

A total of 328 beds and 72 bassinets

* * *

Hospital Addenda

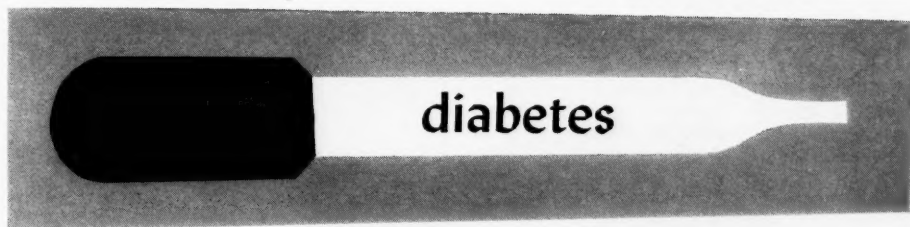
The *Maine* statutes contain a provision that "all hospitals in this state which receive any public funds appropriated to assist in the care of residents of the state shall, subject to the approval of the boards of trustees of the respective hospitals, admit osteopathic physicians who are in good standing

and licensed to practice obstetrics and surgery according to the laws of the state, to treat therein their own paying patients in private rooms, provided, however, that any such hospital may, at its option, set aside certain rooms therein for the use of such physicians as an osteopathic unit."

The development by the osteopathic physicians of their own hospitals in *Maine* has apparently offset any request that any general hospitals otherwise established consider admissions in accordance to the above legislative provision.

* * *

In *Rhode Island* the osteopathic hospital has erected a wing to its present building paid for in
concluded on page 56



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70% were over 40
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1. Blotner, H., and Marble, A.: *New England J. Med.* 245:567 (Oct. 11) 1951.
2. Steine, L.: *GP* 8:45 (July) 1953.

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concluded from page 22

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RHODE ISLAND MEDICAL JOURNAL OSTEOPATHY IN NEW ENGLAND

concluded from page 54

part by public subscription, and in part (\$60,000) by a federal appropriation under the Hill-Burton hospital act. An additional \$15,000 has been requested, and decision on the matter is pending.

Osteopathic Colleges

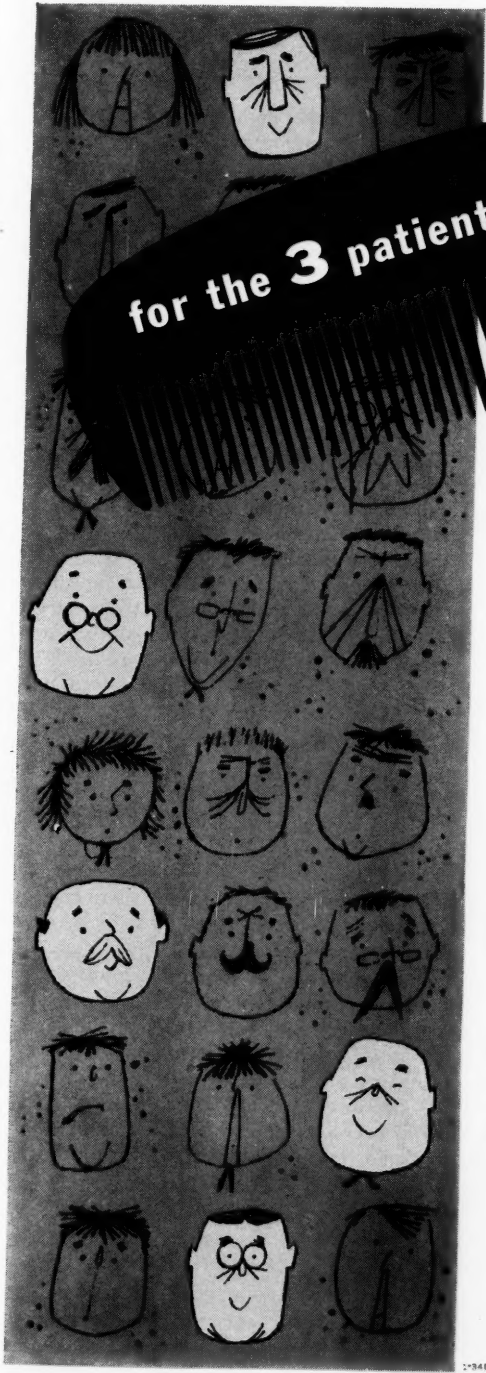
As noted above, the American Osteopathic Association approves of only six colleges for the professional training of osteopathic physicians. The report of the special committee of the American Medical Association Board of Trustees, as published in the *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* (Vol. 153, pp. 734-740, June 20, 1953) gives an excellent review of the organizational structure, faculties, admission requirements, classes, curriculum and quality of instruction in the approved osteopathic colleges.

The most recent bulletins of four of the approved osteopathic colleges available at the time of preparation of this report list 32 New England residents out of a total enrollment of 1,122 students. Division by states is as follows:

Maine	7
New Hampshire	3
Vermont	1
Massachusetts	10
Rhode Island	8
Connecticut	3

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1. Slepian, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

BOOK REVIEW

THE SURGERY OF INFANCY AND CHILDHOOD by Robert E. Gross, M.D., D.Sc., W. B. Saunders Company, Philadelphia and London 1953. \$16.00

In 1941 Doctor Robert E. Gross in collaboration with William E. Ladd, M.D. published a textbook on *ABDOMINAL SURGERY OF INFANCY AND CHILDHOOD*. The book was a detailed summary of abdominal conditions encountered in infancy and childhood systematically presented by subjects including embryology, pathology, symptoms and signs, treatment and results of treatment. It was generously illustrated with clinical, pathological, and roentgenological pictures as well as schematic drawings of operative procedures. The text was sorely needed by the surgical profession and it soon became a necessary addition to the library of doctors interested in infants and children. Although this book filled an enormous vacuum in the surgical literature, it was limited in its contents, as the title states, to only abdominal surgery.

Doctor Gross in his new book *THE SURGERY OF INFANCY AND CHILDHOOD* has now written a book that encompasses almost the whole field of general pediatric surgery which is the only published text of its kind on this subject. The surgical services at the Boston Children's Hospital are divided into a General Surgical, Neurosurgical, Otolaryngological, and Orthopedic service with the other surgical specialties falling under the jurisdiction of or closely associated with the General Surgical service. This book summarizes the past and present experiences of the General Surgical service at this hospital, and includes chapters on urological surgery and thoracic surgery, including the surgery of congenital heart disease in which field Doctor Gross has personally made more contributions than any other single individual. Doctor Robert M. Smith has contributed a chapter on anesthesia and Doctor Donald W. MacCollum a chapter on hypospadias and wringer arm injuries. The surgical repair of harelip and cleft palate and other common anomalies, such as webbed fingers and lop ears, which require plastic surgery, are not included in this volume.

All the advances in the field of general pediatric surgery have been included. For example, on the subject of imperforate anus, the early combined abdomino-perineal operation for a high rectal pouch which has come into vogue since Ladd and Gross' first book was published, is here fully de-

scribed and illustrated. The drawings by Etta Piotti, an outstanding surgical artist, are excellent and a valuable pictorial addition to a clear and organized written text which keynotes the most important points by italics.

The first chapter discusses the field of children's surgery as a specialty and, although Doctor Gross is not recommending the addition of another specialty to the already many subdivisions of surgery, points out the need for surgeons with a special knowledge of the pathology encountered in the diseases of infants and children. It is obvious that all surgeons cannot have special training in pediatric surgery but it is mandatory that those doing this type of work in their communities should become acquainted with the pathological and surgical problems peculiar to these younger patients. It is along these lines that I believe Doctor Gross' text will be of great assistance and in it surgeons, as well as pediatricians, will find the answers to many heretofore poorly understood surgical peculiarities of this age group and in turn will avail themselves of the proper and proven methods of therapy.

There are many operative procedures with special reference to congenital cardiac disturbances that have become so common in the operating rooms of the Children's Hospital in Boston that the reader might be led to believe, because of the clarity in which the subject matter is presented and because of the favorable operative mortality statistics, that these procedures can be performed without too great hazard. If so interpreted without due consideration of the author's unusual experience and ability, general surgeons will inevitably find themselves unable to produce the same excellent results. However, knowledge of these special operative procedures which are clearly presented will aid in establishing the course to be followed and if necessary referring the patient to the proper locale for treatment.

In summary Doctor Gross has made a lasting and most significant contribution to the entire medical profession in writing this book. It is comprehensive and presented in such a straight-forward style that it will undoubtedly be a standard reference for medical students, interns, general practitioners, pediatricians and should be a "must" for all surgeons who undertake surgery on infants and children.

ARNOLD PORTER, M.D.